United States Senate
BUDGET COMMITTEE
Don Nickles, Chairman
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STATEMENT BY
BUDGET COMMITTEE CHAIRMAN DON NICKLES
REGARDING MEDICARE DRUG BILL
June 25, 2003

Mr. President, first I want to make a couple of comments on the bill and then talk about a number of amendments that we'll be working on. I wish to compliment first Senator Frist and Senator Grassley and Senator Baucus for getting us here. I guess I should also compliment President Bush because he's been pushing for us to expand Medicare to include prescription drugs. I happen to share that goal, so I compliment them -- because here we are on the floor of the Senate and I believe in the next 24 - maybe 28 - hours we will eventually pass a Medicare bill that will provide prescription drugs.

That's our objective. That's a good objective. I hope that we'll be successful. I also hope that we'll pass a bill that's affordable and I'm not sure that the bill that we have before us right now meets that definition.

So I want to talk about a little bit what's in the bill and maybe some of the challenges that we have confronting us, but again I want to compliment the Chairman of the Finance Committee because this year we did have a markup in the Finance Committee, and we did report out a bill. I didn't vote for it, and I'll explain why I didn't vote for it, but I hope to vote for a bill either on the floor of the Senate or as the bill comes out of conference. But at least we had a markup.

Last year the Democrats were in control of the Senate, and we didn't have a markup in the Finance Committee. We basically had a markup on the floor of the Senate. We spent some time on this, several weeks I might add, but we didn't pass a bill. It didn't become law. It was very frustrating. We didn't go through the normal process.

This year I don't quite agree with the final outcome as it came out of the Finance Committee, but at least we had a chance. We had a bill. We had a markup. We considered dozens of amendments. We reported out a bill. Now the Senate has been on this bill for two weeks. We considered a lot of amendments. And we'll consider more I'm sure both tonight and tomorrow. So my compliments to the leader and to the chairman of the committee for getting the bill to where we are.

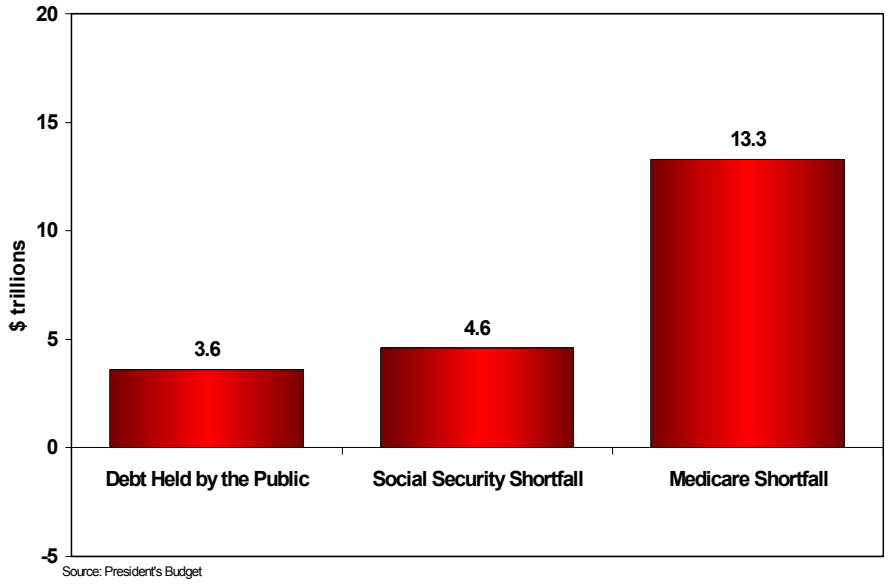
Let me just talk a little bit about the current status of Medicare. Medicare has big challenges confronting it today. It is a very popular program, but it is a program that really can and could and should be improved. It's a very expensive program. The cost of Medicare has more than doubled since 1990. In 1990 we were spending $100 billion. Today we're spending over $250 billion.

But that doesn't show the liabilities that we already have in the system. Medicare has a shortfall -- by shortfall I mean benefits that have been promised that are not funded, not paid for - of $13.3 trillion. Now, that's an enormous sum of unfunded liability.

The total unfunded liability of Social Security is $4.6 trillion. The total debt held by the public $3.6 trillion. So we're looking at a Medicare shortfall that actually exceeds or triples the total amount of debt held by the public.

I've heard many of our colleagues when we talk about raising the debt limit, say, "Oh, we shouldn't do this." But what we're doing on Medicare in the bill that we are considering right now will increase the unfunded liability of Medicare probably by $4 trillion or $5 trillion or $6 trillion - greater than the entire Social Security shortfall and far greater than the debt held by the public.

Social Security & Medicare Unfunded Promises Compared with Debt Held by the Public



Now, this is an enormous expansion of benefits that we're saying we're going to pay for and I think people need to know it.

Is it affordable? Just to pay for the Medicare shortfall today, we have from the budget of the U.S. government in 2004, it says "to pay the actuarial deficiency as a percent of discounted base, we would have to increase Medicare taxes 5.3 percent on top of the 2.9 percent that we're already paying just to pay for this $13.3 trillion."

We'd have to almost triple the Medicare tax which is currently 2.9 percent. This is on all payroll. You'd have to increase it an additional 5.23 percent, according to the government budget – an additional 5.23 percent according to the government budget submission to cover the projections.

Social Security, by comparison, would only have to be raised 1.87 percent.

It shows that at least actuarially, Medicare is in three times as worse shape as Social Security. And that's without us passing additional benefits often top of it and so I want my colleagues to be aware of that.

This is a very unstable house and we're getting ready to build another deck on top of it.

That's the reason why I'm raising some of these concerns. I want our colleagues to be aware of it. Maybe we're going do it anyway. Maybe it is the popular thing to do. But at least -- I don't want it to go without saying, "Wait a minute, did anybody not pay attention to the fact that these are enormous liabilities that are going to be very, very expensive and somebody is going to have to pay the bill sometime?"

Now, in the past we paid for Medicare with a payroll tax. And that's had some limiting effect. When trust funds were drawn down, people said, "Wait a minute, we've got to do something." So there might be a tax increase, there might be some reforms. We passed some reforms just a few years ago. We spent a lot of the last few years maybe undoing some of those reforms but it did save money.

Now we're getting ready to expand Medicare at a level greater than ever since its creation in 1965.

I favor making significant improvements in Medicare. I find the system to be very obsolete in the benefits that it provides. It has a lot of serious short comings.

Medicare doesn't provide prescription drugs. It should. Medicare doesn't have preventive care, ordinary, routine checkups in many areas. It should. A good health plan certainly would do that. It has a deductible, a hospital deductible of $840. That's way too high. Way too high. Then it has a different deductible for doctors. They should be a combined deductible and it should be much lower than $800, $900 combined.

It's a system that leaves a lot to be desired. It doesn't have catastrophic coverage, so if a person gets really sick and they're in the hospital for a long time, after a certain number of days, Medicare doesn't pay it. That doesn't make sense. You really should have insurance to pay for something and this system doesn't do that.

As a matter of fact, a lot of our health care system, in my opinion, is broken because we end up insuring for relatively almost first-dollar costs and we don't insure in some cases for the really expensive things. At least that's the way Medicare is. And that's not a good example. We should change that. You should insure for those events that you can't afford. You shouldn't be insuring for ordinary, routine things that obviously individuals can pay for.

I make the analogy to automobiles. You should insure for the accidents, for the collisions, for something very serious, something very expensive. You shouldn't insure to fill the car up with gasoline or to change the oil.

In health care costs, I'm afraid we insure for almost everything, and that greatly increases the cost.

My major complaint with the bill before us, I want to improve and modernize Medicare. I want to improve Medicare. My mother's on Medicare. I want her to have a better health care system. I want her to have a health care system comparable to what we have for federal employees.

I'd like for senior citizens to have a good base plan and then be able to choose any of a variety of other plans they wish to have. And keep what they want. Or they can choose something better. They can have a competitive system, an integrated benefit system.

Unfortunately, I'm not sure that that's what we're going to pass probably tomorrow night. The bill that we have before us, and the reason why I voted against it in the Finance Committee and may vote against it on the floor of the Senate, is because I find the bill is very expensive and very light on reforms.

It doesn't make as many reforms as I'd like for it to make. And it is very, very expensive on the subsidies. And I've already mentioned the fact that we would have to increase payroll taxes by 5.23 percent just to make up for the shortfall. That doesn't include the drug benefit that I've been told by tax estimators you'd have to add another 7 percent or 8 percent just to pay for the drug

benefits that we're adding.

And I am concerned that the drug benefit that we're adding will be much more expensive than many people estimate. Much more expensive than we're saying. The budget resolution says $400 billion. I compliment the Chairman and also the House. They're staying with the $400 billion estimate.

But I would project that many years from now that it won't be a $400 billion expansion. It will be much closer to $800 billion by the end of ten years. We'll find out. I'm making this speech on the floor. I mean it. This is not just a guess. Maybe it's a little more than a guess.

I think ultimately you'll see a few things happening and I'll talk about the basic benefit we're offering and why I think the costs will exceed our estimates.

The first problem is that the subsidies are very large indeed. We are paying, for people below 160 percent of poverty, the federal government is going to pay almost all of the drug expense.

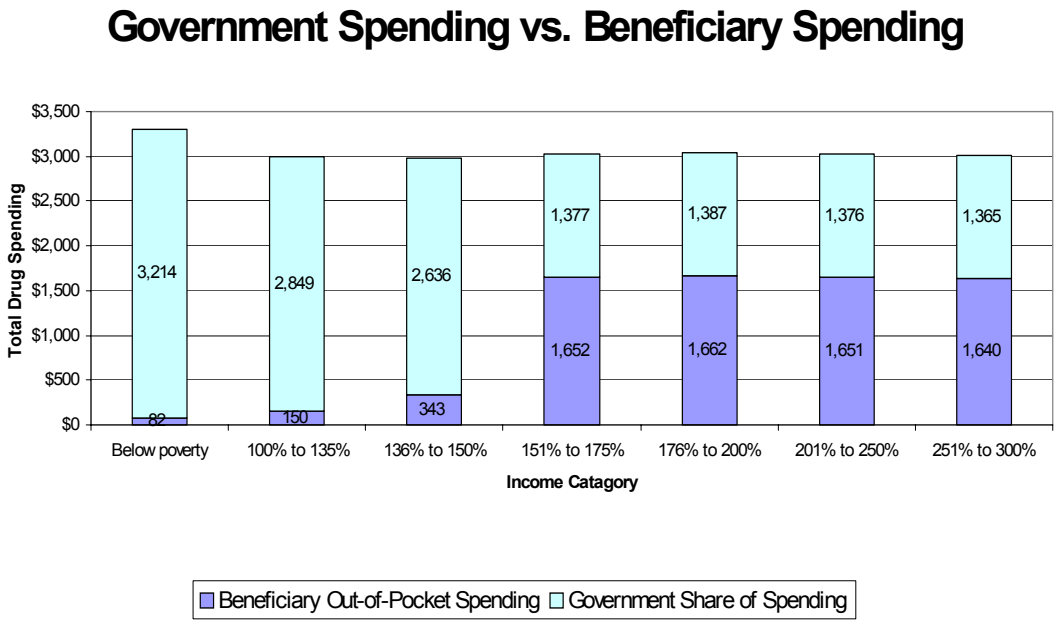
Individuals in this income category have estimated by the Centers for Medicare and Medicaid (CMS), they estimate drug usage of about $3,200 for people below poverty. A little less than $3,000 for incremental levels above that.

But the individuals, the beneficiaries at the lower-income levels pay very little. And the government pays almost all of it. I've heard some people challenge, "Wait a minute, you want to change that?" I'm just questioning, is this really affordable?

For income levels in this category for the lowest income, these are the poorest of our seniors. The individual would pay $82 and the federal government $3,214. The individual pays 2 percent, the federal government pays 97.5 percent. Wow. That is a very high ratio.

The next level is not much different. The individual would pay 5 percent. the federal government pays 95 percent.

The next level up -- and this is income up to about 150 percent of poverty. That's for a couple with income of about $19,576. So the federal government would pay 90 percent and an individual would pay 10 percent.



Those are very generous subsidies. Looking at the estimates, I would guess that if the federal government's going to be paying 97 percent or 95 percent or 90 percent that you'll have drug utilization go up maybe well beyond these figures.

These figures are coming from CMS, and they say, well, those are figures for people with insurance. But I would just guess that the people that are on the -- this level, those are Medicaid-eligibles, and many states have a lot of restrictions on the number of prescription drugs they can have. Many states say you're limited to three a month. If the government is paying 97.5 percent and there is not a limitation of three a month or so many a month it doesn't have the limitations of the states because the states are requiring cost sharing of 30 percent, 40 percent or 50 percent, my guess is it will go up dramatically.

And I think all these levels, utilization will go up dramatically. Maybe I'm wrong. It will remain to be seen. But I'm concerned about at least for these lower-income levels, income levels below 160 percent of poverty that the bill we have before us is probably too generous or maybe not affordable.

Now I hope I'm proven wrong. But I've been in business, and I know when -- I took over management of a company when the company had a plan, a health care plan where the company paid 100 percent of health care premiums and costs, that really wasn't sustainable.

And I think a lot of other businesses found out, wait a minute, that's not affordable. And so we -- most businesses - started putting in 80/20 ratios where the beneficiary would have to pay 20 percent or the beneficiary would have to pay 10 percent.

And I don't mind lower-income people having a smaller co-pay. I am fine with that. But I think we're starting out so generous that it will encourage overutilization and costs will explode.

And it's also hard, once you start out with a percentage like that. I can see us starting at 80 percent and maybe later going to 90 percent.

But it's much harder to go the other direction. I don't see you going from 97 percent down to 90 percent. A future congress may be forced to make those decisions because we may find out that this is not affordable. It may not be sustainable. The demand may be so great that it is not sustainable.

Look at the next chart. Now is this a good deal? Is this a good deal for seniors? Certainly people on the low end -- below 100 percent of poverty level -- and that's an income level for an individual of $9,600 and for a couple of $13,000. They would pay $82 and they would receive almost $3,300 in benefits. Present law, according to CMS, they pay $734.

So the amount they pay goes down almost about 80-some-odd percent. This is a great deal for low-income. The next level they would pay $150. Currently they are paying almost $1,200. Again they would be paying about one-eighth of what they were paying previously and getting a very nice return.

At 136 to 150 percent of poverty, and that would be for individuals with incomes up to, for a couple $19,500. They would pay only $343. Presently they're paying $1,300. So a big improvement for them, and they're receiving about $3,000 in benefits. Very good, generous benefit.

Maybe the most generous benefit anybody could propose is for incomes below 160 percent of poverty.

Above that income level it's not such a good benefit. I've heard a couple of our colleagues complain about it. It's not so good for individuals who have incomes above 160 percent of poverty. That would be individuals with incomes of about $15,400 or a couple of about $21,000. Above that level the formula changes.

Because then they have to pay a premium, $35 a month. Then they have a deductible, $275

a month. Then they receive a drug benefit after they get through the deductible of 50 percent up to $4,500. And then above $4,500 to $5,800 they would have to pay 100 percent. Above that level they get 90 percent. That's not a great drug benefit. It's not great. It's okay, maybe, but not as good as a lot of plans.

As a matter of fact, looking at a lot of plans people now have, just kind of comparing to levels like this, individual for this plan today would be paying, under the new bill would be paying $1,600. That individual today is paying about $1,162. They would end up paying about an extra $500 for maybe a similar-type benefits. It is estimated they receive a total of about $3,000 worth of drugs.

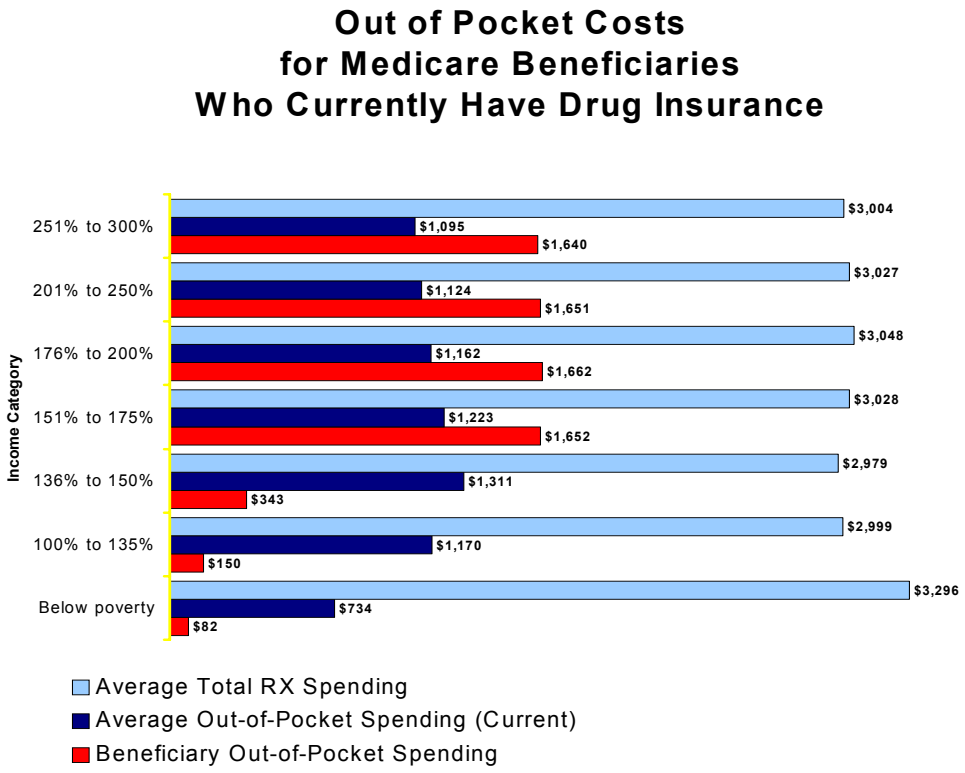
Actually if you look it the upper income, above $21,000 a couple, in every category they pay more under the proposal that we have before us than they are under current law. So it's not a real good deal for them.

Granted it's voluntary. Maybe they'll drop out. If they drop out, it kind of depends on what their health status is. If they're healthy, it may make things worse for the taxpayer. They may not help subsidize for the taxpayer. That remains to be seen.

So this has generous benefits for lower income - below 160 percent of poverty - but it's not such a good deal for upper income. Because a lot of people above 160 percent of poverty have health care.

A lot of people below that have health care. But for them this is a great deal. For 160 percent of poverty and below you can't beat this deal.

Above it, you can beat it. A lot of people have better.



You say what do you mean? They might have a union plan. We had some amendments yesterday that tried to make sure those plans were made whole. We wanted to subsidize them, make sure they didn't lose a dollar. Well, the facts are -- and I believe that the Congressional Budget Office estimated that 37 percent of people who have private health care coverage are going to lose those plans and go into this government plan.

They have health care through their employer and their employer's going to say if Uncle Sam's going to do this, why don't you get your health care or your drug benefits through Uncle Sam instead of through the employer?

As a matter of fact, a lot of employers are struggling to pay for retirees' health care benefits, and so they would welcome this. So you'll see a lot of companies dumping or dropping their health care coverage even though it may well be more generous than what we have proposed before us in this bill.

Likewise, the states, many states have drug programs, many of which may be more generous not necessarily for the low-income, but they may have a plan, they may have some system, some other type of entity that we will be picking up. Granted, most of the state plans for low-income, states are making a contribution, maybe it's a combination of state and federal through Medicaid. But if they're dropping it now where the states were making a contribution in the past, we will be assuming that.

So this is a big federalization, frankly, of a benefit that's provided both in the public sector and in the private sector.

Seventy-seven percent of seniors today have some type of drug insurance, drug coverage. And this is going to preempt most of that and say the federal government is going to take it over. In some cases not do as good a job as what the private sector has already done. Maybe not even as good as I would expect -- I would expect as good as most of the public sector.

Is it affordable? Well, the estimates are that it's $400 billion. Let me -- I've already mentioned that I'm concerned that at least on the levels where the federal government subsidies are 97 percent or 95 percent or 90 percent that utilization will exceed expectations.

If the government's going to pay most of the cost of the drugs, my guess is people are going to say give me more of those drugs.

There's not a restriction that's going to say, you can go to one doctor, go to this specialist for whatever ails you. You can go to another specialist for whatever ails you. Frankly, if the government is going to be picking up 95 percent of the drug care cost, people are going to say give me some of those.

And they are going to see some ads on tv that it may say Celebrex and has a great rhyme to it or they see some other ad and they say that looks good and they will say, "Doctor give me some of that."

And if Uncle Sam is going to be paying 97 percent of the cost, why not? That makes your patient happy. Maybe it will work, maybe it won't.

My guess is you're going to see utilization go up greatly for any category where a third party or the government is paying 90-some-odd percent of drug costs. I think utilization will soar and I think that will greatly drive up costs.

I also think in the drug benefit formula, where you have basically a formula for above 160 percent of poverty where the government says, okay, you pay your $35 a month and you pay your deductible, $275, and then government will match you 50 percent up to the first $4,500, a lot of people who might have drug annual expense in the average neighborhood of $1,200 or $1,300 may say I don't get my money back until I use or consume $1,300 worth of drugs. And I'm paying a monthly premium. Therefore, I'm going to start taking advantage of it. If Uncle Sam's going to be

paying 50 percent, I want more. And so their utilization may go up and may go up dramatically. So that could increase costs.

Then you have this so-called bubble. Amounts above $4,500 to $5,300 where presently the individuals would pay for 100 percent of it. A lot of people are going to say, wait a minute, we need to fill that up.

They're going to say, wait a minute, we get 50 percent up to $4,500 then it stops. Then we go to catastrophic. Let's fill that in. The estimates were by some if you fill that in it will cost you another $200 billion. My guess is we're not going to do it this year but we'll do it sometime probably in the next three to four years. That will cost a bunch of money.

Then they'll say that's not high enough. The subsidies for low income, let's move it to up 200 percent of poverty. When you make those kind of changes and I know many of the advocates want to do that, they stated that, I acknowledge that and I think everybody here should acknowledge that that's their desire and I suspect they would be successful.

There would be a lot of people saying this is not near as good a deal as I have right now so they are going to lobby congress. We need a greater share. We need a greater match. Why go 50/50? Can't we go 60/40? Can't we go 80/20? Can't we insure the donut and fill in that whole amount.

When you make those changes you have bill that won't cost $400 billion. It will cost $800 billion by the last year, and this is a spending line that is going to be going straight up, and so I am concerned about that. I am concerned about the expense of it.

And I am thinking well wait a minute, what do we do to make up for the damage. Did we make changes that would make it more affordable. Did we make some reforms? Some of which are not easy.

I have been an advocate for increasing the eligibility age - making Medicare the same age for a recipient of Medicare to be the same age as Social Security. Right now to receive Social Security you don't receive Social Security at age 65 you receive full retirement Social Security at 65 and 10 months. And by the year 2021, you have to be 67 to receive Social Security.

I happen to think because people are living longer and because Medicare has such enormous financial problems, we should make Medicare eligibility age concurrent with Social Security. Basically by the year 2022, that would you have to be 67 before you could receive Medicare.

I know that's not an easy vote but frankly this Senate has voted for it just a few years ago. We voted for it I believe with 62 votes. We passed it. We can and could and should pass it again. It would save our kids a lot of Medicare taxes. So that's one reform. I doubt that we are going to offer that amendment but it has been proposed and been discussed and I think should seriously be considered.

Another amendment that I expect we will offer - by Senator Feinstein, myself and Senator Chafee tomorrow and that's basically means testing Part B premiums. And I will talk about Part B premiums and it gets too confusing for a lot of people but we subsidize Medicare.

Most people think we pay for Medicare just with the payroll tax. The payroll tax I already mentioned is very deficient. As a matter of fact, it is 2.9 percent of all income, not capped. If someone has hand income of a million dollars a year, Michael Jordan I think he makes more than that, if they have income of $1 million a year they pay $29,000 into Medicare yet we still going broke.

The actuaries say you have to add another 5.2 percent on top of it - 8.1 percent - to pay for the liability we currently have, and that's without a drug benefit.

If you add a drug benefit you need to add another percentage on top of that. Now you are talking about real money. You are talking about 9 percent the liability that we have in Medicare. We need to make reforms.

One of which would be to means test part B premiums. Payroll tax pays a lot of money but general revenue pays a lot of money into Medicare.

Just to give you an example. This year, general revenue, not payroll tax, general revenue from all taxpayers in the year 2003 will put into Medicare about $81 billion. In the year 2013 it will be more than -- $189 billion. So it more than doubles and does not keep up.

The general revenue portion is the individual recipient pays one fourth of part B premiums - and this is what pays the doctors - the recipient pays one fourth of it and the taxpayer, the general revenue fund pays three-fourths of it.

So what that means is we are asking our kids to be paying for three-fourths of our doctors visits. Well, I think at least for upper-incomes we shouldn't be asking our kids that are maybe making $20,000 or $15,000 or $30,000 to be paying part of the doctor bills for at least the wealthier seniors. Not all senior s are low income.

So the amendment that we have that we will be considering probably tomorrow, tomorrow evening, would say instead of having a 25 percent co-pay for beneficiaries on Part B, if your income is very high, it would be 50 percent. Or if it is much higher it would be 100 percent. I believe the levels are, if as an individual had an income of $75,000 and $150,000 for a couple, their percentage would increase from 25 percent to 50 percent.

And then likewise if the individual had income of $100,000 or the couple had income of $200,000, they would have to pay 100 percent of their premium. We wouldn't subsidize them.

That would take pressure off the system.

The Part B fund -- most recent trustee report states, SMI - that's Part-B revenues in 2002 were equivalent to 7.8 percent of personal federal income tax collected that year.

If such taxes remain at the current level relative to the national economy, Part B general revenue financing in the year 2077 - 75 years from now - would represent roughly 32 percent of total income taxes.

Now that is staggering. That's about a third of all income taxes would have to be paid just to pay the Part B subsidies we now have in the system. That is not sustainable.

So my point being, we have to have a Medicare system that provides better benefits, yes. I agree. We also have to have a Medicare system that is sustainable for future generations for our kids and grandkids. We want to have a system they can afford.

So I just mention these as two reforms and one other one I am going to mention on the primary reform that's in the underlying bill provides for a private sector health care plan, most of the time we call it a P.P.O., a Preferred Provider Organization. Similar to many of the health care plans across America that are providing integrated structural benefit.

They don't just provide drugs, they provide all health care benefits. They provide the hospital, the doctor, access to specialist and drugs. That's what's in most people's health care plans today. That is not Medicare.

We would like to update and upgrade Medicare to bring it into the 21st Century so it has comparable benefits. So you can have an integrated management system so the individuals that are in the system say yes, this doctor, they control your drugs and they control your visit to the hospital and the specialist. You have really good quality care.

We don't have that in Medicare today. The real reform in what many of us are hoping we can do is improve Medicare so you can have preventive health care. So you can have more screenings. So you can have catastrophic coverage. So you can have prescription drugs. All as part of one package, like federal employees, like other health care, like a lot of the union plans out there today.

We don't have that in Medicare today. So we are trying to make that a viable alternative to the present system. So if some individual wants to stay in the present system they can but if they would like to choose a better, more modern system, more integrated system, they can do that.

And I very much hope to work to see that the P.P.O. model will actually become a reality that is a real viable alternative.

CBO estimates that the underlying bill that only a couple of percent would participate in the new P.P.O.'s. Two percent. That's a failure.

CMS, the Center for Medicare and Medicaid, estimates it may be as high as 42 or 43 percent. I would like for that to be the case. I think that maybe overly optimistic.

I think we need to work to improve this section of the bill. I know that Senator Grassley and Senator Baucus have an amendment to maybe make a small step in that direction. I compliment them for it. But I for the life of me think if this is the only reform in the bill that we have, and we don't even have competitive bidding until the year 2009, that's not real reform.

So I hope to be or expect to be a conferee on this bill. I am going to work to see that we have real competition as a viable alternative improvement to improve quality Medicare for all seniors. They should at least have that option. I think in the bill we have right now, I don't see it.

But I want to work to make that happen. I think that is -- that's one key we are hanging on for reform that's in the bill before us.

We don't have Part B means testing. We don't have eligibility age. We didn't make the tough decisions to help save Medicare and make it more affordable for future generations.

What we are doing is basically spending a lot of general revenue money to provide benefits that frankly are long overdue. I would hope that we would make some of these improvements in conference. Or maybe on the floor.

We are going to try and make one or two of these tomorrow and I hope that they would pass to make this a better bill. I want to support this package. I want to pass a Medicare bill. I want to improve Medicare for all seniors.

I'm afraid right now the bill is heavy on subsidies and short on reform. Short on improvements. Short on making real structural substantial savings that will save the system for future generations. I want to save the system for seniors today and I want to save is it for future generations tomorrow. And I will work with my colleagues both in the House and in the Senate and in the conference to try to achieve that objective.